2018 GPD NOFA Technical Assistance: Low Demand GPD Housing Models

Scott Young, Paul Smits, Roger Casey, Jeff Quarles, & Amanda Barry

Overview of Low Demand GPD Housing Models
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Introductions

• VA GPD National Program Office
  – Jeff Quarles, Director
  – Amanda Barry, Program Specialist

• VA National Center on Homelessness among Veterans (NCHV)
  – Roger Casey, Director of Education & Training

• University of South Florida
  – Scott Young, Research Assistant Professor
  – Paul Smits, Senior Policy Analyst
The Plan

• Establish Low Demand GPD housing programs that are based on harm reduction principles
• Low Demand GPD programs seek to prepare Veterans for permanent housing options
• Applicants who have documented a need for a Low Demand GPD Program must identify and link their application to a specific local Continuum of Care
• VA will then place that application into the funding priority established by the Continuum of Care analysis
Why Do We Need New Approaches Like Low Demand Models?
Ending Homelessness among Veterans

• VA is actively promoting innovative programs to eliminate homelessness among all Veterans

• Traditional housing programs require sobriety and compliance with TX as a condition of both admission and continued stay

• Many Veterans cannot, or will not, stop drinking or using, and often do not qualify for housing programs
  – Many chronically homeless Veterans fall into this category

• Low Demand models utilize a low demand/harm reduction strategy to serve homeless Veterans that cannot be reached by traditional homeless programs
The Low Demand Model Core Principles

- Target *chronically homeless* with mental illness and/or substance use problems
- Target individuals who have been unsuccessful in traditional programs
- **Do not** require sobriety or compliance with treatment as a condition of admission or continued stay
- Demands are kept to a minimum
- Environment of care is as non-intrusive as possible
- Rules focus on staff and resident safety
- Residents should not be expelled for minor rule infractions
- Residents are proactively engaged to participate in groups, classes, and programming, but are not forced to participate in programming
The Evidence Base

• The evidence base supporting Low Demand models is significant:
  – GPD programs: Schinka, Casey, Kasprow, & Rosenheck (2011)
  – HUD-VASH programs: Tsai, Kasprow, & Rosenheck (2014)
Model Development Process and Successful Pilot Initiatives

• In FY 2014, GPD and Center staff began collaborating with subject matter experts from University of South Florida to develop an implementation process for Low Demand programs specifically tailored to GPD.

• Low Demand programs have been successful in getting a unique population of chronically homeless Veterans off of the streets and into housing programs.
Performance Metrics

• Low Demand GPD sites are expected to achieve the following performance metrics regarding discharges:
  – At least 50% to permanent housing
  – Less than 23% negative exits
The History of Low Demand Outside of VA

• The Early Low Demand Homeless Programs were called Safe Havens
• First Safe Haven opened in 1984 (Privately Funded)
• 1992 Amendments to the McKinney Homeless Assistance Act Authorized Federal Funding of Safe Havens
• McKinney Act defined Safe Havens as *a form of supportive housing that serves hard-to-reach homeless persons with severe mental illness who are on the street and have been unable or unwilling to participate in supportive services.*
• McKinney Act specified:
  - 24-hour residence for eligible persons who may reside for an unspecified duration
  - private or semiprivate accommodations
  - overnight occupancy limited to 25 persons
  - low-demand services and referrals
  - supportive services to eligible persons
Lessons Learned: VA’s Experience with Low Demand Models

• Philosophy
  – Demands are low, expectations are high
  – Low Demand does not mean No Demand
  – Rules should focus on resident and staff safety

• Empower Veterans
  – Incentivize participation
  – Use peer support for orientation and assistance
  – Give residents a voice (e.g., resident council, community meetings)
More Lessons Learned:
VA’s Experience with Low Demand Models

• Staffing
  – All staff should be familiar with and support the model
  – Frequent staff interaction with Veterans is encouraged
  – Ongoing communication between VA and Provider is critical
  – Non-confrontational methods of responding to intoxication
  – Tolerance to minor infractions of rules
  – Stay continuously engaged with Veterans through highs and lows
More Lessons Learned:
VA’s Experience with Low Demand Models

• Be a good neighbor
• Safe keeping of medication
• Physical Design
  – Proximity of staff offices to Low Demand beds
  – Common areas to encourage interaction
  – Procedures for signing in and out are encouraged
  – Amnesty boxes
  – Safe Rooms and Sober Lounges
Providers’ Experiences with Safe Rooms: Why were they created?

- Response to aggressive behavior at the facility
- Effort to minimize disruptions
- Alternative to police involvement / Deterrent to police contact
  - Motivation of program staff and administration
- Desire to increase retention rates
Providers’ Experiences with Safe Rooms: What is their purpose?

- To ensure client safety
- To monitor client health and behavior
- To provide private area for recovery from substance use, medication effects, or unmanageable emotional distress
- To provide a private space for any client needing it
Typical Operation of the Safe Room

• Staff direct residents who are escalating to the Safe Room.
• Resident is instructed to spend 15 minutes in the Safe Room.
• Staff are able to observe residents in the Safe Room through a window on the door to the room.
• If a resident falls asleep in the room, staff make sure that resident is in a recovery position.
• Resident is offered food and non-alcoholic beverages by staff.
• At the 15 minute mark, staff re-evaluate the resident and determine if the Veteran is appropriate to re-enter the community.
• If resident falls asleep, he/she is allowed to stay in the room for additional time if appropriate.
Encountering Resistance

• Many sites have noted resident resistance to using the Safe Room
• If resident is resistant to entering or staying in the Safe Room, he or she is allowed to take a 15 minute walk in the community instead
• Possible techniques to manage resistance:
  – Prior to Safe Room use, remind veteran that the facility is a calm, therapeutic environment
  – Ensure veteran of the need to observe them for their safety
  – Encourage veteran to think how their behavior affects their fellow Veterans
  – Create a comfortable environment in the Safe Room (comfortable furniture, food and drink)
• If resistance to staff direction continues, police may be contacted in those instances
• The GPD handbook currently denotes the following regarding absences from facilities:
  – “A Veteran who is absent without approval from the GPD funded program community provider with no expectation of return must be discharged after 24 hours and the appropriate exit form in HOMES must be completed.”

• Different programs have different policies (e.g., HCHV-funded Low Demand / Safe Havens)
Special Considerations for Low Demand GPD Housing Programs

- Size (typically 20 beds or less)
- Location
- Physical separation from sobriety based programs
- On site staffing 24/7 at same location as residents
- Resident Orientation to the program, designed to set the expectations
- Monitoring comings and goings
- Management of introduction of contraband
More Considerations

• Case management is required
• Mental health and substance use treatment are optional but encouraged
• Integration with Sobriety Based Programs
  – How do I explain the rules of this program to residents in other programs?
  – Modifying SOPs and Rules for the New Program
  – Low Demand and Zero Tolerance Policies
More Considerations

• Safe Medication Practices for Low Demand Programs
• Veterans with Overdose Kits
• Management of Clients Who Return Impaired
• AWOLs and Continuous Engagement
More Considerations

• Management of Violence and Threats of Violence
• Handling Introduction of Drugs and Alcohol
• Introduction of Weapons
• Amnesty Boxes
• Managing Rule Infractions without Expelling Residents
Skills Sets Needed by Staff

• Flexibility and adaptability
• Experience with motivational interviewing
  – Be encouraging but not insisting
  – Meet client where they are (pre-contemplation)
• Leave the rules of a sobriety-based program behind
• Use relapses and infractions as opportunities for engagement
• Patience and working with the client’s recovery in very small steps
• Tolerance to minor infractions of rules
Ongoing Technical Assistance (TA) and Support

• The Learning Curve - Doing this Takes Practice
• Two TA Calls Each Month
• Annual fidelity review process (different than the annual GPD inspection)
Questions? / Discussion